Community Support Services Referral

http://www.northeastcss.ca/

North East Ontario Home & Community Care
United in our Commitment to Care
Soins communautaire et à domicile du Nord-Est de l'Ontario
Unis dans notre engagement

Ontario
North East Local Health Integration Network
Réseau local d'intégration des services de santé du Nord-Est

If faxed, include number of pages (including cover): _____ pages

Client Details and Demographics

Health Card #: _____ Version: _____ Province Issuing Health Card: Ontario

☐ No Health Card # ☐ No Version Code First Nation Status # (if applicable): _____

Surname: _____ Given Name(s): _____

Home Address: _____ Municipality/City: _____ Province: Ontario

Postal Code: _____ ☐ No Known Address

Telephone: ext. Alternate Telephone: ext. ☐ No Alternate Telephone

Date of Birth: _____ Gender: ◯ M ◯ F ◯ Other

What is your mother tongue? ◯ English ◯ French ◯ Other (Specify): _____ Interpreter Required? ◯ Yes ◯ No

If neither French nor English, in which of Canada's official languages are you most comfortable? ◯ English ◯ French

Comments: _____

Primary Alternate Contact Person: _____ Relationship: _____

Check if applicable: ☐ Power Of Attorney (☐ Documentation viewed) ☐ Substitute Decision Maker ☐ Other: _____

Telephone: ext. Alternate Telephone: ext. ☐ No Alternate Telephone

Conduct call-back with: (please check one): ◯ Client or ◯ Alternate Contact or ◯ Client wishes to be contacted by e-mail

Best time to call: _____ Email address: _____

Requested Community Service

Requested Community Service (please check off all that apply):

- ☐ Acquired Brain Injury Services
- ☐ Adult Day Programs
- ☐ Alzheimer/Dementia Services
- ☐ Assisted Living/Supportive Housing
- ☐ Care for the Caregiver
- ☐ Deaf and Impaired Hearing
- ☐ Exercise and Falls Prevention Programs
- ☐ Foot Care
- ☐ Friendly Visiting – Social/Safety
- ☐ Group/Congregate Dining
- ☐ Home Help and Homemaking
- ☐ Home Maintenance
- ☐ Hospice Palliative Care
- ☐ Independence Training and Rehabilitation
- ☐ Meals on Wheels
- ☐ Personal Emergency Response Services
- ☐ Personal Support and Independence Training
- ☐ Post Vision Loss Services
- ☐ Professional Services (Nursing, OT, PT) offered by First Nation Providers
- ☐ Respite
- ☐ Rides and Transportation
- ☐ Stroke Services
- ☐ Telephone Reassurance and Security Checks

Referrer Information

Referring Facility/Unit: _____ Facility Contact Number: ext.

Completed By: _____ Title: _____ Date: _____

Contact #: ext. Fax #: _____

Follow-up Required: ◯ Yes ◯ No ☐ Consent to refer obtained from client

This form contains personal health information that is subject to the provisions of the *Personal Health Information Protection Act.* The information is collected for the purpose of referring patients to local community support agencies which offer services that may benefit them. Community support agencies will only use the information to assess patient eligibility and arrange services as required.